

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 weeks after death.

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30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06721 CERTIFICATE OF DEATH 06720										
1. DECEASED-NAME (Type or print) James Wright Carter			2a. DATE OF DEATH May Month 28 Day 1969 Year			2b. HOUR 4:45 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 1, 1901		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline County Md.				
10. CITY OR TOWN OF DEATH Federalburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 104 Park Lane			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Owner		12b. KIND OF BUSINESS OR INDUSTRY Sunshine Laundry		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Federalburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 104 Park Lane	
14. FATHER'S NAME First Middle Last William T. Carter, Jr.			15. MOTHER'S MAIDEN NAME First Middle Last Hattie Wright							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-12-2478		17. INFORMANT Address Mrs. Mildred C. Carter, Federalburg, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 3 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Exogenous obesity										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2-12-66 , 19____, to 5-28-69 , 19____, that (I) (we) last saw the deceased alive on 5-28-69 , 19____, and that in (m) (our) opinion death occurred on the date and hour stated from the causes stated above, (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE Frank M. Anderson M.D.					22c. DATE SIGNED 5-29-69		22d. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.			
22e. ADDRESS Federalburg, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 31, 1969		23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City or Town) (County) (State) Hurlock Dorchester Md.				
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalburg, Md.					25a. REC'D BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

†S. 540.

Submitted: July 1997; Accepted: February 1998

912 97

Discharge: 10/11/19, 12/1/19, 12/15/19, 12/29/19, 1/12/20, 1/26/20, 2/9/20, 2/23/20, 3/7/20, 3/21/20, 4/4/20, 4/18/20, 5/2/20, 5/16/20, 5/30/20, 6/13/20, 6/27/20, 7/11/20, 7/25/20, 8/8/20, 8/22/20, 9/5/20, 9/19/20, 10/3/20, 10/17/20, 10/31/20, 11/14/20, 11/28/20, 12/12/20, 12/26/20, 1/9/21, 1/23/21, 2/6/21, 2/20/21, 3/6/21, 3/20/21, 4/3/21, 4/17/21, 4/30/21, 5/14/21, 5/28/21, 6/11/21, 6/25/21, 7/9/21, 7/23/21, 8/6/21, 8/20/21, 9/3/21, 9/17/21, 9/30/21, 10/14/21, 10/28/21, 11/11/21, 11/25/21, 12/9/21, 12/23/21, 1/6/22, 1/20/22, 2/3/22, 2/17/22, 2/28/22, 3/13/22, 3/27/22, 4/10/22, 4/24/22, 5/8/22, 5/22/22, 6/5/22, 6/19/22, 7/3/22, 7/17/22, 7/31/22, 8/14/22, 8/28/22, 9/11/22, 9/25/22, 10/9/22, 10/23/22, 11/6/22, 11/20/22, 12/4/22, 12/18/22, 1/1/23, 1/15/23, 1/29/23, 2/12/23, 2/26/23, 3/12/23, 3/26/23, 4/9/23, 4/23/23, 5/7/23, 5/21/23, 6/4/23, 6/18/23, 7/2/23, 7/16/23, 7/30/23, 8/13/23, 8/27/23, 9/10/23, 9/24/23, 10/8/23, 10/22/23, 11/5/23, 11/19/23, 12/3/23, 12/17/23, 1/10/24, 1/24/24, 2/7/24, 2/21/24, 3/7/24, 3/21/24, 4/4/24, 4/18/24, 5/2/24, 5/16/24, 5/30/24, 6/13/24, 6/27/24, 7/11/24, 7/25/24, 8/8/24, 8/22/24, 9/5/24, 9/19/24, 10/3/24, 10/17/24, 10/31/24, 11/14/24, 11/28/24, 12/12/24, 12/26/24, 1/9/25, 1/23/25, 2/6/25, 2/20/25, 3/6/25, 3/20/25, 4/3/25, 4/17/25, 4/30/25, 5/14/25, 5/28/25, 6/11/25, 6/25/25, 7/9/25, 7/23/25, 8/6/25, 8/20/25, 9/3/25, 9/17/25, 9/30/25, 10/14/25, 10/28/25, 11/11/25, 11/25/25, 12/9/25, 12/23/25, 1/6/26, 1/20/26, 2/3/26, 2/17/26, 2/28/26, 3/13/26, 3/27/26, 4/10/26, 4/24/26, 5/8/26, 5/22/26, 6/5/26, 6/19/26, 7/3/26, 7/17/26, 7/31/26, 8/14/26, 8/28/26, 9/11/26, 9/25/26, 10/9/26, 10/23/26, 11/5/26, 11/19/26, 12/3/26, 12/17/26, 1/10/27, 1/24/27, 2/7/27, 2/21/27, 3/7/27, 3/21/27, 4/4/27, 4/18/27, 5/2/27, 5/16/27, 5/30/27, 6/13/27, 6/27/27, 7/11/27, 7/25/27, 8/8/27, 8/22/27, 9/5/27, 9/19/27, 10/3/27, 10/17/27, 10/31/27, 11/14/27, 11/28/27, 12/12/27, 12/26/27, 1/9/28, 1/23/28, 2/6/28, 2/20/28, 3/6/28, 3/20/28, 4/3/28, 4/17/28, 4/30/28, 5/14/28, 5/28/28, 6/11/28, 6/25/28, 7/9/28, 7/23/28, 8/6/28, 8/20/28, 9/3/28, 9/17/28, 9/30/28, 10/14/28, 10/28/28, 11/11/28, 11/25/28, 12/9/28, 12/23/28, 1/6/29, 1/20/29, 2/3/29, 2/17/29, 2/28/29, 3/13/29, 3/27/29, 4/10/29, 4/24/29, 5/8/29, 5/22/29, 6/5/29, 6/19/29, 7/3/29, 7/17/29, 7/31/29, 8/14/29, 8/28/29, 9/11/29, 9/25/29, 10/9/29, 10/23/29, 11/5/29, 11/19/29, 12/3/29, 12/17/29, 1/10/30, 1/24/30, 2/7/30, 2/21/30, 3/7/30, 3/21/30, 4/4/30, 4/18/30, 5/2/30, 5/16/30, 5/30/30, 6/13/30, 6/27/30, 7/11/30, 7/25/30, 8/8/30, 8/22/30, 9/5/30, 9/19/30, 10/3/30, 10/17/30, 10/31/30, 11/14/30, 11/28/30, 12/12/30, 12/26/30, 1/9/31, 1/23/31, 2/6/31, 2/20/31, 3/6/31, 3/20/31, 4/3/31, 4/17/31, 4/30/31, 5/14/31, 5/28/31, 6/11/31, 6/25/31, 7/9/31, 7/23/31, 8/6/31, 8/20/31, 9/3/31, 9/17/31, 9/30/31, 10/14/31, 10/28/31, 11/11/31, 11/25/31, 12/9/31, 12/23/31, 1/6/32, 1/20/32, 2/3/32, 2/17/32, 2/28/32, 3/13/32, 3/27/32, 4/10/32, 4/24/32, 5/8/32, 5/22/32, 6/5/32, 6/19/32, 7/3/32, 7/17/32, 7/31/32, 8/14/32, 8/28/32, 9/11/32, 9/25/32, 10/9/32, 10/23/32, 11/5/32, 11/19/32, 12/3/32, 12/17/32, 1/10/33, 1/24/33, 2/7/33, 2/21/33, 3/7/33, 3/21/33, 4/4/33, 4/18/33, 5/2/33, 5/16/33, 5/30/33, 6/13/33, 6/27/33, 7/11/33, 7/25/33, 8/8/33, 8/22/33, 9/5/33, 9/19/33, 10/3/33, 10/17/33, 10/31/33, 11/14/33, 11/28/33, 12/12/33, 12/26/33, 1/9/34, 1/23/34, 2/6/34, 2/20/34, 3/6/34, 3/20/34, 4/3/34, 4/17/34, 4/30/34, 5/14/34, 5/28/34, 6/11/34, 6/25/34, 7/9/34, 7/23/34, 8/6/34, 8/20/34, 9/3/34, 9/17/34, 9/30/34, 10/14/34, 10/28/34, 11/11/34, 11/25/34, 12/9/34, 12/23/34, 1/6/35, 1/20/35, 2/3/35, 2/17/35, 2/28/35, 3/13/35, 3/27/35, 4/10/35, 4/24/35, 5/8/35, 5/22/35, 6/5/35, 6/19/35, 7/3/35, 7/17/35, 7/31/35, 8/14/35, 8/28/35, 9/11/35, 9/25/35, 10/9/35, 10/23/35, 11/5/35, 11/19/35, 12/3/35, 12/17/35, 1/10/36, 1/24/36, 2/7/36, 2/21/36, 3/7/36, 3/21/36, 4/4/36, 4/18/36, 5/2/36, 5/16/36, 5/30/36, 6/13/36, 6/27/36, 7/11/36, 7/25/36, 8/8/36, 8/22/36, 9/5/36, 9/19/36, 10/3/36, 10/17/36, 10/31/36, 11/14/36, 11/28/36, 12/12/36, 12/26/36, 1/9/37, 1/23/37, 2/6/37, 2/20/37, 3/6/37, 3/20/37, 4/3/37, 4/17/37, 4/30/37, 5/14/37, 5/28/37,

Figure 1

Page 10 of 10

CS-10-2

THE UNIVERSITY OF CHICAGO

Abb. 2.57: Die 10 größten Städte in der Welt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
06722		CERTIFICATE OF DEATH						06721					
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M		
William			V.		Combs				May 31 1969				
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Apr. 25, 1915				54 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
N. Carolina			U.S.A.					Caroline Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Rural Greensboro			None				Retired Railroad			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Caroline		Greensboro		YES <input type="checkbox"/> NO <input type="checkbox"/>		None				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last				
Charles Combs									Della Pruitt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address								
No			241-26-5252		Ila Wood Greensboro, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic C.V.Dis.</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 20, 1968</u> , to <u>May 31, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Chas. H. Stonesifer</u> DEGREE							ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>June 1 '69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Chas. H. Stonesifer, M.D.</u>							22e. ADDRESS <u>Greensboro, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			6-4-69		Rachel			Roaring River N.C.					
24. FUNERAL DIRECTOR ADDRESS <u>J. E. Bouleais Greensboro, Md.</u>							25a. REC'D BY REGISTRAR <u>WEN 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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[illegible]

000-1678070

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U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) BESSIE			First LEE			Middle FAULKNER			2a. DATE OF DEATH MAY 2 1969				
3. SEX F		4. RACE W		5. DATE OF BIRTH JULY 12 1900			6. AGE (In years lost birthday) 68 YRS.		2b. HOUR M				
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH CAROLINE			Md.			
10. CITY OR TOWN OF DEATH RURAL DENTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. CITY OR TOWN CAROLINE DENTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First JOHN			Middle WOOTERS			15. MOTHER'S MAIDEN NAME First JENNIE			Middle SMITH			Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. (If you give war or dates of service)			17. INFORMANT W.M. N. FAULKNER			Address DENTON				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Anterior infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF PTB Stage 1 (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/24/67 , 19__, to 5/25/69 , 19__, that (I) (we) last saw the deceased alive on 3/25/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Philip Felipe			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/5/69				
22d. PHYSICIAN'S NAME (Type) Philip Felipe			22e. ADDRESS Denton, MD										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE MAY 7, 1969			23c. NAME OF CEMETERY OR CREMATORY CONCORD			23d. LOCATION (City or Town) (County) (State) CONCORD CAR. MD.				
24. FUNERAL DIRECTOR CHARLES V. MOORE			ADDRESS DENTON MD.			25a. REC'D BY REGISTRAR MAY 9 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

1900

AND

THE

LANDS

OF THE

STATE

OF

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS 113 4/168
30M REC

06724

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06723

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A. M.					
SARAH		MILDRED	FOUNTAIN	May 21 1969		A. M.						
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Female	White		June 24, 1918		50 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.		
Delaware		USA				Caroline						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
Ridgely		504 Park Avenue		Housework		Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Maryland		Caroline		Ridgely		504 Park Avenue						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
William L. Taylor					Dorothy Moore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No				222-01-2337		Thurman Fountain, Ridgely, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF <u>Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1963</u> <u>6 years</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/5/69</u> , 19 <u>69</u> , to <u>5/21</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>5/21/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Philip P. Felipe MD</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/24/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Philip P. Felipe MD</u>					22e. ADDRESS <u>Denton Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		May 24, 1969		Denton Cemetery		Denton, Maryland						
24. FUNERAL DIRECTOR <u>Frankton Funeral Home, Federalburg, Maryland</u>					25a. REC'D BY REGISTRAR <u>MAY 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Robert J. Jones</u>					

THE UNIVERSITY OF CHICAGO

1950

(10)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18, Part 2 Film 413 5-5-69 ams 06725												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												06724			
1. DECEASED-NAME (Type or print) Blanche C. Hinspeter								2a. DATE OF DEATH 5-22-69 Day Year								2b. HOUR M											
3. SEX Female				4. RACE Cau.				5. DATE OF BIRTH 1-25-17				6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN											
7a. BIRTHPLACE (State or foreign country) N.Y.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Caroline Md.															
10. CITY OR TOWN OF DEATH Greensboro				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None				12a. USUAL OCCUPATION (Kind of work done during most of working life, agent retired.) housewife				12b. KIND OF BUSINESS OR INDUSTRY None															
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md				13b. COUNTY Caroline				13c. CITY OR TOWN Greensboro				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER None													
14. FATHER'S NAME First Middle Last Arthur De Rochemont								15. MOTHER'S MAIDEN NAME First Middle Last Rose Ttsdelle																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 123-07-2447				17. INFORMANT Address John Hinspeter Greensboro, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Tuberculosis																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from June 5, 1968 , to May 22, 1969 , that (I) (we) lost the deceased alive on May 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE Charles H. Stonesifer DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																22c. DATE SIGNED May 24 1969											
22d. PHYSICIAN'S NAME (Type) Chas. H. Stonesifer, M.D.																22e. ADDRESS Greensboro, Md. 21639											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5-26-69				23c. NAME OF CEMETERY OR CREMATORY Greensboro				23d. LOCATION (City or Town) (County) (State) Greensboro, Md.															
24. FUNERAL DIRECTOR J. E. Boulais ADDRESS Greensboro, Md.																25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06726

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06725

1 DECEASED-NAME (Type or print) First Middle Last Henry Franklin Jester			2a. DATE OF DEATH Month Day Year May 26 1969			2b. HOUR 12:10	
3 SEX Male		4 RACE White		5. DATE OF BIRTH January 27, 1894		6 AGE (In years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline County Md.	
10 CITY OR TOWN OF DEATH Federalsburg		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. #1 - Hynson		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) State Roads Commission-State of Md		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R.F.D. # 1- Hynson		14 FATHER'S NAME First Middle Last William Jester		15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Planche			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-01-8650		17 INFORMANT Mrs. Florence E. Jester, Federalsburg, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 8 hrs							
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic myocardial Failure 5 yrs							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-17-68, to 5-26-69, that (I) (we) last saw the deceased alive on 5-26-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank M. Anderson				22c. DATE SIGNED 5-27-69		22d. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.	
22e. ADDRESS Federalsburg, Md. 21632							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg Caroline Md.	
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Md.				25a. REC'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06727

06726

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> c. LENGTH OF STAY IN TB <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>none</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> d. STREET ADDRESS <u>Backland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>E.</u> Last <u>La Plarte</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1969</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 18, 1944</u>	
9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	
13. FATHER'S NAME <u>Benjamin La Plarte</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>001-14-3219</u>	
17. INFORMANT <u>Robert Wright</u>		18. ADDRESS <u>Preston, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20d. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> <u> </u> <u> </u> 19<u> </u>, to <u> </u> <u> </u> <u> </u> 19<u> </u>, that (I) (we) last saw the deceased alive on <u> </u> <u> </u> <u> </u> 19<u> </u>, and that death occurred at <u> </u> <u> </u> <u> </u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u> </u>		22b. DATE SIGNED <u>5/22/69</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 19,</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order</u>		23d. LOCATION (City, town or county) <u>Preston, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>MAY 29 1969</u>	

MEDICAL CERTIFICATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health for or to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) EVELYN JANE SCHALL										2a DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year 19 10 6 6		2b HOUR AM			
3 SEX F		4 RACE W		5 DATE OF BIRTH SEPT 5, 1902		6 AGE (in years not birthday) 66 YRS		7 UNDER YEAR MONTHS 0 DAYS 0		8 UNDER 24 HRS. HOURS 0 MIN. 0		2c DATE PRONOUNCED DEAD Month 1 Day 1 Year 19		2d HOUR AM	
7a BIRTHPLACE (State or foreign country) MD				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH CAROLINE			
10 CITY OR TOWN OF DEATH NEAR DENTON				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE MD				13b COUNTY CAROLINE				13c CITY OR TOWN DENTON				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME First HENRY Middle A Last SAMIS				15 MOTHER'S MAIDEN NAME First CLARA Middle PHILLIPS Last PHILLIPS				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO				16b SOCIAL SECURITY NO			
17 INFORMANT ROBERT SCHALL				ADDRESS DENTON, MD.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 598X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none to my knowledge															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE [Signature]				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 1/21/69							
EXAMINER'S NAME (Type) CHARLES MOORE				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ADDRESS DENTON MD.				ADDRESS (Street, city, town, or county) DENTON MD.											
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b DATE MAY 26, 1969				23c NAME OF CEMETERY OR CREMATORY GREENMOUNT							
23d LOCATION (City or Town) (County) (State) HILLSBORO CAR. MD.				25a RECD BY REGISTRAR BUN 2 1969				25b REGISTRAR'S SIGNATURE [Signature]							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>William Andrew Shortall</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>5</i> Day <i>27</i> Year <i>69</i>		2b. HOUR <i>6:48</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>5/14/1902</i>	6. AGE (In years from birthday) <i>67</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>5</i> Day <i>27</i> Year <i>1969</i>		2d. HOUR <i>7</i> M	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Caroline</i> Md			
10. CITY OR TOWN OF DEATH <i>Preston</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farming</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>503 Mt. Pleasant Place</i>	
14. FATHER'S NAME First <i>William J.</i> Middle <i>Shartall</i> Last				15. MOTHER'S MAIDEN NAME First <i>Maude</i> Middle <i>Andrews</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>217-36-0970</i>		17. INFORMANT ADDRESS <i>Mrs. W. Andrew Shortall, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109 Ventricular Fibrillation Massive Myo-</i> DUE TO, OR AS A CONSEQUENCE OF <i>cardial Infarction</i> (b) <i>cardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe coronary insufficiency</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>5 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Heart Disease Generalized arterial sclerosis</i>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>[Signature]</i>		EXAMINER'S NAME (Type) <i>Harold B. Plummer M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>5/29/69</i>			
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>5/31/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or Town) <i>Easton, Md.</i> (County) (State)			
24. FUNERAL DIRECTOR <i>MURICE E. NEUNAM & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
				DATE <i>JUN 3 1969</i>					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06729

1. DECEASED-NAME (Type or Print) <u>RAYMOND CHARLES WOOD JR.</u>										2a. DATE KNOWN OF DEATH <u>35/1/69</u> 19 <u>10</u> P. <u>M</u>		2b. HOUR <u>10</u> P. <u>M</u>			
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>OCT 14, 1919</u> 49 YRS.		6. AGE (In years last birthday) <u>49</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>		2c. DATE PRONOUNCED DEAD <u>3/5/69</u> Day <u>3</u> Year <u>19</u> 3:35 A. <u>M</u>		2d. HOUR <u>35</u> A. <u>M</u>	
7a. BIRTHPLACE (State or foreign country) <u>MD</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH <u>CAROLINE</u> Md.			
10. CITY OR TOWN OF DEATH <u>DENTON</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u></u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Electrician</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>				13b. COUNTY <u>CAROLINE</u>				13c. CITY OR TOWN <u>DENTON</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u></u>	
14. FATHER'S NAME First <u>RAYMOND</u> Middle <u>C.</u> Last <u>WOOD SR.</u>						15. MOTHER'S MAIDEN NAME First <u>ELIZABETH</u> Middle <u></u> Last <u>LAWLESS</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16b. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>STEVE WOOD, RIDGELY MD.</u>				ADDRESS <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>9520</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 hour</u> <u>4 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION <u></u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u></u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>				21b. TIME OF INJURY Month, Day, Year <u>3/5/69</u> 19 <u>10</u> P. <u>M</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Falls from Exhaust pipe into trunk of</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>				21f. LOCATION Street or R.F.D. No. <u>East Market Street</u> City or Town <u>Denton</u> County <u>Caroline</u> State <u>MD</u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>3/5/69</u>							
EXAMINER'S NAME (Type) <u>Charles B. Blumberg M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county) <u>Denton Caroline</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>May 5, 1969</u>				23c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>							
24. FUNERAL DIRECTOR <u>CHARLES MOORE</u>				ADDRESS <u>DENTON MD.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>							
				DATE <u>MAY 9 1969</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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